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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G065	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	4316 ALABAMA AVE, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 24, 2008 through June 27, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a resident population of four men with various disabilities. In addition, a focused review was conducted of a third client's behavior management needs. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. The determination was made that the facility was not in compliance with the Condition of Participation in Client Protections.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's governing body provided general operating direction, except in the following areas: The findings include: 1. Cross-refer to W120, W159 and W436. There was no evidence that the governing body had established an effective quality assurance system to ensure that clients received appropriate and necessary supports and services in the home and through outside service providers (i.e. day	W 104		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 programs and dental services). 2. Cross-refer to W149. The governing body failed to ensure that persons assigned to conduct investigations had received appropriate training, in accordance with facility policies.	W 104	The Qmrp was trained by the Incident Management Coordinator on the internal investigation. Refer to attachment # 1a Furthermore, the Qmrp is scheduled for the Incident Management training with DDS on Refer to attachment # 1b In the future the governing body will ensure that the person conductiong the investigation has received appropriate training in accordance with the facility policies.	7-15-08 8-06-08.
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: A. Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to ensure that needs were met, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. On June 25, 2008, at 12:06 PM, Client #1 was presented his lunch plate at the day program which included sliced turkey on whole wheat bread, ground tossed salad, peas in a cream sauce, fruit cocktail and beverages. At 12:14 PM, the client had finished eating about 50% of the sandwich. The turkey was observed sliding out of the bread while the client continued to bite into the sandwich. Using his fingers, he removed the turkey from the bread, put it in his mouth and continued taking bites of turkey. The day program nurse arrived while the client was eating his lunch. She indicated that Client #1 enjoyed his sandwiches whole and will get angry when they are cut. She also indicated that he will on occasion refuse to use a fork. At 12:16 PM, the client was observed to cough several times. After	W 120	Individual # 1 was relocated to another residence on 7-03-08; however his new Qmrp will ensure that the day program provides the adequate services to ndividual #1. The Qmrp will report to the day program two (2) times weekly or as needed during mealtime to monitor the mealtime protocol in addition to the monthly monitoring starting Additionnally, the Qmrp will train the day program nurse and staff on individual #1 diet Refer to attachment #2 In the future the facility will ensure that the day program provides individual #1 diet as prescribed.	7-31-08 7-31-08

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W 120	Continued From page 2 completing his meal at 12:26 PM, the client spit several pieces of fruit cocktail onto the floor and then coughed several times more. Further interview with the nurse revealed that he was prescribed a mechanical soft, low fat, high fiber diet (ground meats - moist with low fat gravy). There was no evidence that the day program provided Client #1 with ground meat, as prescribed. 2. Cross-refer to W484. Client #1's prescribed adaptive equipment was not available for use at his day program. a. On June 25, 2008, at 12:06 PM, Client #1's lunch was served at the day program on a Styrofoam plate and with a plastic fork. He had difficulty eating with the fork, as well as a plastic teaspoon. He resorted to eating with his hands. At 12:11 PM, the Styrofoam plate slid across the table while he was eating. There was no specialized adaptive equipment being used at the day program. Interview with day program staff indicated no specialized eating equipment had been provided to the day program for the client. On June 25, 2008, review of Client #1's Occupational Therapy (OT) assessment, April 5, 2008, included recommendations for Hi-Lo plate and the Dycem mat to prevent sliding. At the time of the survey, the Dycem mat was available for use in the home but not at the day program. b. On June 24, 2008, beginning at approximately 12:16 PM, review of Client #1's Individual Support Plan (ISP), dated November 21, 2007, revealed that he was prescribed "a plate guard and a spoon with a smaller bowl to prevent overloading of his utensil during mealtime." To date, the	W 120	The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program. 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program. 7-29-08	

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W 120	Continued From page 3 facility had not purchased a spoon with a smaller bowl and built-up handle for use at day program. B. Based on staff interview and record review, the facility failed to effectively monitor each client's dental services to ensure that needs were met, for one of two clients in the sample. (Client #2) The finding includes: On June 26, 2008, at 6:01 PM, review of Client #2's dental records revealed that on September 10, 2007, the dentist determined that tooth #9 was fractured and needed restoration. The client returned to the dentist on March 10, 2008 and had his teeth cleaned and polished. There was no mention of the September 10, 2007 assessment of tooth #9. At 6:05 PM, neither the QMRP nor the LPN Coordinator knew the status of Tooth #9. The LPN Coordinator added that she would check with the dentist to see whether there had been a problem with securing authorization from the funding source (Medicaid insurance).	W 120	The follow up visit is scheduled for 9-15-08 In the future, the LPN Coordinator, and Qmrp will attach a copy of the previous visit consult to ensure that the dentist reviews the record of the last visit with the previous recommendations.	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed the facility failed to establish and implement policies and procedures to prevent neglect and ensure clients' safety during mealtime and medication administration [W149]; failed to ensure that all incidents were investigated by persons who had received training	W 122		

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W 122	Continued From page 4 on investigation techniques, in accordance with the incident management policy, to protect client health and safety [See W149]; and failed to implement Client #2's physician order for Food Diary, to include all nutritional intake [See W159.2]. The effects of these systemic practices results in the failure of the facility to ensure the clients' safety and well being.	W 122	Refer to W149 P.5 & 6 (A. 1 & 2) Refer to W 159.2 P 14	7-31-08
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: I. Based on observation, interview and record review, the facility failed to establish and implement policies and procedures to prevent neglect and ensure clients' safety for two of two clients in the sample. (Clients #1 and #2) A. The facility failed to ensure that dietary textures and adaptive equipment were provided as prescribed to protect client health and safety as evidence below: 1. The QMRP and the LPN Coordinator were unaware of Client #1's assessed risk for aspiration. On June 24, 2008, at 8:44 AM, interview with the Qualified Mental Retardation Professional (QMRP) and the LPN Coordinator indicated that Client #1 was not known to be at risk of aspiration. They stated that his meats were to be	W 149	Refer to W 120 (1, 2) P.2 P.3	

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W 149	Continued From page 5 "finely chopped" with gravy added "to be secure in the swallowing process, since he doesn't have any teeth to chew." Later that day, however, at approximately 12:16 PM, review of the client's Individual Support Plan (ISP), dated November 21, 2007, revealed the following "I require monitoring for pace while eating and drinking. I must sip rather than gulp, due to risk of aspiration." The client's physician's orders for June 2008 did not reflect "finely chopped. Instead, the diet order was as follows: "mechanical soft, low fat, high fiber diet, ground meats (moist with low fat gravy)." 2. Client #1's prescribed dietary texture was not implemented at his day program. On June 25, 2008, at 12:06 PM, Client #1 was presented his lunch plate at the day program which included sliced turkey on whole wheat bread, ground tossed salad, peas in a cream sauce, fruit cocktail and beverages. At 12:14 PM, the client had finished eating about 50% of the sandwich. The turkey was observed sliding out of the bread while the client continued to bite into the sandwich. Using his fingers, he removed the turkey from the bread, put it in his mouth and continued taking bites of turkey. The day program nurse arrived while the client was eating his lunch. She indicated that Client #1 enjoyed his sandwiches whole and will get angry when they are cut. She also indicated that he will on occasion refuse to use a fork. At 12:16 PM, the client was observed to cough several times. After completing his meal at 12:26 PM, the client spit several pieces of fruit cocktail onto the floor and then coughed several times more. Further interview with the nurse revealed that he was prescribed a mechanical soft, low fat, high fiber	W 149	All staff were inserviced on individual #'s1 diet Refer to attachment # 3 In the future, the facility will ensure that the diet is provided as prescribed. Individual # 1 was relocated to another residence on 7-03-08; however his new Qmrp will ensure that the day program provides the adequate services to individual #1. The Qmrp will report to the day program two (2) times weekly or as needed during mealtime to monitor the mealtime protocol in addition to the monthly monitoring starting Additionnally, the Qmrp will train the day program nurse and staff on individual #1 diet Refer to attachment #2 In the future the facility will ensure that the day program provides individual #1 diet as prescribed.	7-21-08 7-31-08 7-31-08

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W 149	Continued From page 6 diet (ground meats - moist with low fat gravy). There was no evidence that the day program provided Client #1 with ground meat, as prescribed. 3. Client #1's prescribed adaptive equipment was not available for use at his day program. On June 25, 2008, at 12:06 PM, his lunch was served at the day program on a Styrofoam plate and with a plastic fork. He had difficulty eating with the fork, as well as a plastic teaspoon. He resorted to eating with his hands. At 12:11 PM, the Styrofoam plate slid across the table while he was eating. There was no specialized adaptive equipment being used at the day program. Interview with day program staff indicated no specialized eating equipment had been provided to the day program for the client. Also on June 25, 2008, there was an updated Occupational Therapy (OT) assessment, April 5, 2008, in which the OT documented that he had observed Client #1 eating with his hand, and with his face down close to his plate. The OT also indicated that the direct support staff had informed him that the client often spilled his food when eating with the spoon. The April 2008 OT update included recommendations for Hi-Lo plate and the Dycem mat to prevent sliding. At the time of the survey, the Dycem mat was available for use in the home but not at the day program. 4. Client #1's prescribed spoon (built-up handle with small bowl size) was not available for use in the home or at his day program. On June 24, 2008, beginning at approximately 12:16 PM, review of Client #1's Individual Support	W 149	The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment 7-24-08 These adaptive equipment were provided to the day program 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program 7-29-08	

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W 149	Continued From page 7 Plan (ISP), dated November 21, 2007, revealed that he was prescribed "a plate guard and a spoon with a smaller bowl to prevent overloading of his utensil during mealtime." To date, the facility had not purchased spoons with smaller bowl for use in the home and at day program. 5. The facility failed to verify that Client #1 received an updated swallow study while hospitalized in January 2008 and to obtain the results for inclusion in the client's record. On June 24, 2008, beginning at 7:31 AM, review of Incident reports revealed that Client #1 had been hospitalized with pneumonia in January 2008 and again in June 2008. At approximately 9:50 AM, interview with the Incident Management Coordinator (IMC) revealed that although Client #1 was "prone to develop pneumonia," he was not aware of any implications regarding his swallowing. At 10:07 AM, review of the client's chart revealed that the most recent speech language assessment was dated January 15, 2007. The most recent documented, swallow study was performed on October 13, 2004 (due to frequent respiratory infections). The October 13, 2004 report indicated that the oral phase was within normal range. The esophageal phase, however, had not been viewed because the client was unable to tolerate the position required for evaluation. The assessment, therefore, had not been comprehensive. On June 26, 2008, after the LPN Coordinator indicated that the hospital had conducted an updated swallow study in January 2008, review of the hospital discharge report, dated January 30, 2008, revealed: "He has passed all swallow evaluations and is eating a pureed diet currently with advancement as tolerated to full diet." Further interviews and	W 149	The Qmrp has ordered individual # 1 adaptive equipment on These adaptive equipment were provided to the day program Individual # 1 former nurse will contact the Case Manager or attorney to request the copy of the swallowining studies completed while individual #1 was a the hospital.	7-24-08 7-29-08 7-31-08

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W 149	Continued From page 8 record review revealed no evidence that the facility sought to obtain a copy of report(s) of any swallow studies that may have been conducted while he was hospitalized in January 2008. In addition, it was unclear whether the hospital had assessed the client's tolerance of food textures other than pureed and had defined what they meant by "full diet." 6. Client #2's prescribed dietary texture was not implemented in the facility. According to Client #2's physician's orders (POs), dated June 1, 2008, his foods were to be "finely chopped." On June 24, 2008, at 8:03 AM, the four clients were given 2 slices of reduced-fat turkey bacon with breakfast. Client #2's bacon, however, remained in strips and had not been finely chopped. There was no evidence that the facility ensured that his foods were consistently served finely chopped, in accordance with POs. B. The facility failed to address timely Client #2's repeated episodes of gagging and/or vomiting while taking large antibiotic pills. On June 24, 2008, at 6:19 AM, a direct staff person reported that Client #2 "threw up his antibiotics" just moments earlier. The medication nurse reportedly had documented the incident in his record. This was later confirmed in the nurse progress notes. According to this same staff person, the nurse reportedly told her that they were "considering liquid medications instead." 1. The QMRP and LPN Coordinator were interviewed later that morning, beginning at 9:07 AM. Client #2 reportedly chewed his medications. Initially, the LPN Coordinator said she thought the	W 149	All staff were inserviced on individual # 2's diet Refer to attachment #4 In the future, the facility will ensure that individual #2's diet is implemented as prescribed. The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	7-31-08 7-28-08 7-31-08

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W 149	Continued From page 9 antibiotic pills, which were larger than a typical pill, might have "a nasty taste." Yet, moments later both she and QMRP stated that the client "tolerates the chewing, taste" and had not complained. The antibiotics were prescribed for boils on his legs. They reported he was treated for a similar eruption on his legs in April 2008. The first boils had cleared but new ones appeared in June. Neither the QMRP nor the LPN Coordinator indicated that liquid medications were being considered and there was no evidence that the gagging/ vomiting had been identified as a concern. 2. On June 26, 2008, beginning at 2:24 PM, review of Client #2's Nurse Progress Notes revealed numerous entries documenting his difficulties with the antibiotic pills during the first round of antibiotic treatment in April, as follows: 4/5/08 7AM - "...Took AM meds. Staff reported individual vomited out after taking meds..." 4/5/08 7PM - "Refused to swallow whole pills. Accept and swallow pills broken down in pieces. No vomiting reported." 4/6/08 7AM - "Took all meds when broken down in pieces." 4/7/08 6:40 PM - "...Immediately after swallowing his antibiotics, he projectile vomiting and vomited up his Augmentin and Bactrim..." 4/8/08 6:15 AM - "... having trouble swallowing large antibiotic pills causing him to gag, pills given in apple cause one at a time after breaking in half..." There were additional nurse progress notes from April indicating choking, gagging and/or vomiting. Further review of the notes revealed nurses on different shifts had used different administration techniques; some nurses broke the pills into pieces while others did not.	W 149	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	

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W 149	Continued From page 10 3. At 3:05 PM, review of a summary of Client #2's April 11, 2008 "Medication Review" by his medical team revealed no indication that the distress caused by the antibiotic pills had been discussed at their meeting. Review of the client's primary care physician (PCP) notes, dated May 7, 2008 and June 4, 2008, showed no evidence that the PCP had been made aware of the gagging and vomiting in April. 4. Client #2's most recent episode of boils began in June 2008. According to his Medication Administration Record, he began receiving Bactrim at 7 PM on June 20, 2008. He vomited on June 24th. There was no evidence that the facility established an effective means of communication within the nursing team, to ensure timely response to the client's medical concerns (i.e. vomiting pills), to include conveying relevant information to the primary care physician. 5. There was no evidence that the QMRP effectively monitored Client #2's medication tolerance. II. Based on interview and record review, the facility failed to ensure that all incidents were investigated by persons who had received training on investigation techniques, in accordance with the incident management policy, to protect client health and safety. The findings include: On June 24, 2008, at 8:21 AM, review of incident reports revealed that on April 27, 2008, Client #1 fell off a chair and sustained a head injury when he hit his head against a wall. The corresponding	W 149	The medication nurses were inserviced to report any incident of difficulty ingesting medication to the nursing team, and the PCP on a timely manner for appropriate intervention. The designated nurse will monitor the medication nurses bi-weekly to ensure that that the medication nurses administer the medications as ordered. The qmrp will communicate with the nurse coordinator on a daily basis to follow up on the medication pass report.	7-31-08 7-31-08 7-31-08

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W 149	Continued From page 11 investigation report was reviewed and disclosed conflicting information. Additionally, the investigation report was neither signed nor dated. The investigation report stated that he fell at 3:00 PM, whereas the incident report had stated that it had occurred at 5:25 PM. The investigation report indicated that staff had administered first aid, whereas the incident report showed the nurse had applied first aid (with no documentation that direct support staff had administered first aid). The investigation report stated that the client's chair had been in the dining room, whereas the incident report indicated the chair had been located in the living room. On June 24, 2008, the Qualified Mental Retardation Professional (QMRP) was interviewed at 8:44 AM. The QMRP stated that she had conducted the investigation, beginning that same day. The QMRP acknowledged having failed to sign and date the report. She acknowledged that the 3:00 PM time indicated in the investigation report had been in error. She could not explain the discrepancy between the incident and investigation reports as to who had applied first aid to Client #1's head, and at what time. On June 26, 2008, at 10:26 AM, review of the facility's Incident Management Policy, dated November 2007, revealed the following: The Incident Management Committee (IMC) shall "ensure that incidents are investigated in a timely manner and that they are documented and	W 149	The Qmrp was trained by the Incident Management Coordinator on the internal investigation. 7-15-08 Refer to attachment # 1a Furthermore, the Qmrp is scheduled for the Incident Management training with DDS on 8-06-08. Refer to attachment # 1b In the future the governing body will ensure that the person conductiong the investigation has received appropriate training in accordance with the facility policies.	

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W 149	Continued From page 12 signed... Investigations shall be conducted only by employees of RCM who have completed competency-based investigative training conducted or approved by DHS/DDS." The facility policy also outlined what needed to be included in investigation reports and further required that investigative reports "be reviewed and approved by RCM's IMC..." At 11:34 AM, the QMRP acknowledged that she had not attended DDS training on conducting investigations nor had she attended a comparable, approved training for investigators. During the June 27, 2008 Exit Conference, at approximately 4:00 PM, the facility's Incident Management Coordinator, Program Coordinator and the Chief Operating Officer all acknowledged that the April 27, 2008 incident and/or investigation report had not been reviewed by the IMC, in accordance with the facility's policy. It should be noted that the facility's 911 policy included "Head Injury" in the list of medical emergencies for which 911 should be called. 911 had not been called when Client #1 sustained a one-inch cut on the back of his head "with minimal bleeding" on April 27, 2008, at 5:25 PM. A nurse progress note indicated that by 7:00 PM, a medication nurse had assessed him, provided first aid treatment and the client was not taken to the ER.	W 149	The Qmrp was trained by the Incident Management Coordinator on the internal investigation. Refer to attachment # 1a Furthermore, the Qmrp is scheduled for the Incident Management training with DDS on Refer to attachment # 1b In the future the governing body will ensure that the person conductiong the investigation has received appropriate training in accordance with the facility policies. Furthermore, all investigation reports will be reviewed by the Incident Management Coordinator. The 911 policy is revised to specify the head injury that requires ER visit for evaluation includes change in mental status such as confusion, loss of consciousness and changes in speech or communication, laceration and bleeding that can not be controlled with first aid treatment. Refer to attachment # 6	7-15-08 8-06-08. 7-31-08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by:	W 159		

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W 159	Continued From page 13 Based on observation, staff interview and record verification, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor services for one of the four clients residing in the facility. (Clients #1 and #2) The findings include: 1. Cross-refer with W120. The QMRP failed to collaborate with Client #1's day program to ensure that his prescribed dietary texture was implemented. 2. According to a Nutrition quarterly, dated April 4, 2008, Client #2 weighed 155 pounds in March 2008. The client was assessed by his primary care physician (PCP) on June 19, 2008. The PCP noted a 7 pound weight loss within the past 2 months and ordered the facility to maintain a "food diary of all intake for 1 week." On June 26, 2008, at 12:41 PM, the QMRP presented a "Food Consumption Record" book for review. The FC Record book did not provide information regarding nutrient intake at his day program, Monday - Friday. When asked, the QMRP acknowledged that neither she nor the House Manager or the nurse had instructed the day program to maintain a record of his intake. Further interview revealed no evidence that the facility sought to determine Client #2's nutritional intake while at day program for inclusion in the diary, as ordered by the PCP. [Note: At 5:47 PM, the Nutrition quarterly, dated April 4, 2008, indicated that Client #2's body weight had dropped prior to April 2008. She documented a 10-pound drop from165 pounds in January 2008 to 155 pounds in February 2008.] 3. Cross-refer to W331. On June 24, 2008,	W 159	Refer to W 120 (1) P.2 The physician ordered to maintain a "food diary of all intake for one week" was implemented in the facility; however, the Qmrp failed to ensure that the day program is provided with the form to implement the physicain order by collecting data. In the future, the facility will ensure that the prescribed services are implemented at the facility as well as at the day program.	

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W 159	Continued From page 14 Client #2 vomited after taking antibiotic pills. Interviews with the QMRP and LPN Coordinator later that day suggested that this had not been identified as a concern previously. However, review of nurse progress notes revealed numerous, documented incidents of his gagging and/or vomiting during a previous round of antibiotic treatment, in April 2008. There was no evidence that the QMRP had monitored his nursing/ medication needs in April, to ensure a coordinated response from the medical team to address the gagging. He vomited again on June 24, 2008, four days after resuming antibiotic treatment for a new boil on his leg. There was no evidence that the QMRP effectively monitored his medication tolerance.	W 159	The qmrp will communicate with the nurse coordinator on a daily basis to follow up on the medication pass report.	7-31-08
	4. Cross-refer to W120.2. The QMRP failed to monitor and coordinate Client #2's dental services to ensure timely repair of a fractured tooth #9.		The follow up visit is scheduled for 9-15-08 In the future, the LPN Coordinator, and Qmrp will attach a copy of the previous visit consult to ensure that the dentist reviews previous recommendations.	
	5. The QMRP failed to coordinate Client #3's behavior support needs, to effectively address food stealing, as follows: a. On June 24, 2008, at 6:47 AM, Client #3 came down the stairs from his bedroom on the second floor. A staff person had been assisting him upstairs just moments earlier. That staff person, however, remained upstairs. Client #3 quickly walked into the kitchen and immediately removed a package of cookies from a cabinet. At 6:49 AM, he was observed standing alone in the kitchen and stuffing cookies into his pant pocket. A minute later, staff returned to the kitchen, unaware that the client had just taken cookies and the client left the kitchen hurriedly. On June 26, 2008, at 1:30 PM, the LPN		All staff were re-inserviced on individual #3 BSP as well as on the individual monitoring. Refer to attachment #7 a & b In the future, the facility will ensure that the Staff implement individual # 3 BSP as written, and monitor him frequently.	7-31-08

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W 159	Continued From page 15 Coordinator stated that one of Client #3's targeted behaviors was securing foods between meals without authorization. She stated that he was "fast" and required constant staff supervision. The QMRP arrived minutes later. At approximately 1:35 PM, the QMRP also stated that Client #3 moved quickly, adding that staff "must maintain visual" contact "at all times" or he will take advantage of the situation. On June 26, 2008, at 1:49 PM, review of Client #3's Behavior Support Plan (BSP), dated December 2007, revealed that his diagnoses included Obsessive Compulsive Disorder and Intermittent Explosive Disorder. His targeted behaviors included "attempts to secure food... in excess of his dietary guidelines..." The QMRP, who was still present at the time, stated again that staff must keep the client in sight at all times. This, however, was not explicitly outlined in his written BSP. Instead, the BSP indicated that in the past, he would take food if he was out of "direct visual supervision of staff i.e., more than 5 minutes..." The QMRP replied "no," when asked if he required one-on-one staffing. She also indicated that this had not been discussed by his interdisciplinary team. The QMRP stated that the facility had "ample staff." And yet during the same interview, she acknowledged that staff had found raw meat in Client #3's pants pocket earlier that month. There was no evidence that the QMRP sought further input from the interdisciplinary team to address to the client's ongoing behavior and review his supervision needs. b. Further review of the BSP revealed that staff were to "secure all edible items, when they are not being presented as part of a meal or snack	W 159	All staff were re-inserviced on individual #3 BSP as well as on the individual monitoring. Refer to attachment #7 a & b In the future, the facility will ensure that the Staff implement individual # 3 BSP as written, and monitor him frequently. All staff were re-inserviced on individual #3 BSP as well as on the individual monitoring. Refer to attachment #7 a & b In the future, the facility will ensure that the Staff implement individual # 3 BSP as written, and monitor him frequently.	7-31-08 7-31-08

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W 159	Continued From page 16 time." The June 24, 2008 observation of Client #3's taking cookies while unsupervised revealed the QMRP's failure to ensure that staff implemented effective measures to secure food items between meals.	W 159		
W 224	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assess adaptive behaviors and/or independent living skills, for one of the two clients in the sample. (Client #2) The finding includes: The facility failed to assess Client #2's skills, strengths and deficits for participating and/or self-administration of finger sticks as follows: On June 24, 2008, at approximately 9:00 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #2 was diabetic. On June 26, 2008, at 10:04 AM, the LPN Coordinator confirmed that the client had been diagnosed with diabetes approximately one year earlier, for which he received weekly finger sticks to monitor blood glucose levels. She further indicated that his willingness to participate in the finger stick process had not been assessed. On June 27, 2008, at 1:27 PM, review of Client #2's "Self-Medication Administration" assessment, dated December 10, 2007,	W 224	The Nurse Coordinator has developped a goal for individual #2 to participate in his finger sticks for self-management. Refer to attachment # 5b In the future, the nursing team will ensure that self medication goals are deveopped to allow individual #2 self management.	7-28-08

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W 224	Continued From page 17 confirmed that the client's skills and/or willingness to participate in finger sticks for self-management had not been assessed.	W 224		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide timely medical care, for one of the two clients in the sample. (Client #2) The finding includes: Cross-refer to W331. On June 24, 2008, Client #2 vomited after taking antibiotic pills. The medication nurse reportedly told a direct support staff person that they (medical team) were "considering liquid medications instead." Interviews with the QMRP and LPN Coordinator later that day suggested that gagging/ vomiting had not been identified yet as a concern. However, review of nurse progress notes revealed numerous, documented incidents of gagging and/or vomiting during a previous round of antibiotic treatment, in April 2008. There was no evidence that the nursing team had dealt with the issue in April 2008 and there was no evidence that the concern was brought to the primary care physician's attention. In June 2008, the client developed another boil, for which he was again prescribed one of the antibiotic pills (Bactrim) that he had gagged on in April. He vomited after taking the pill on June 24, 2008. There was no documented evidence that the facility ensured that the client's medical team addressed timely	W 322	The medication nurss were inserviced to report any incident of difficulty ingesting medication to the nursing team, and the PCP on a timely manner for appropriate and immediate intervention.	7-31-08

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W 322	Continued From page 18 the difficulties that he had with swallowing the large antibiotic pills.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely nursing services to meet client needs, for one of the two clients in the sample. (Client #2) The findings include: On June 24, 2008, at 6:19 AM, a direct staff person reported that Client #2 "threw up his antibiotics" just moments earlier. The medication nurse reportedly had documented the incident in his record. This was later confirmed in the nurse progress notes. According to this same staff person, the nurse reportedly told her that they were "considering liquid medications instead." a. The QMRP and LPN Coordinator were interviewed later that morning, beginning at 9:07 AM. Client #2 reportedly chewed his medications. Initially, the LPN Coordinator said she thought the antibiotic pills, which were larger than a typical pill, might have "a nasty taste." Yet, moments later both she and QMRP stated that the client "tolerates the chewing, taste" and had not complained. The antibiotics were prescribed for boils on his legs. They reported he was treated for a similar eruption on his legs in April 2008. The first boils had cleared but new ones appeared in June. Neither the QMRP nor the LPN Coordinator indicated that liquid medications	W 331	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	

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W 331	Continued From page 19 were being considered. b. On June 26, 2008, beginning at 2:24 PM, review of Client #2's Nurse Progress Notes revealed numerous entries documenting his difficulties with the antibiotic pills during the first round of antibiotic treatment in April, as follows: 4/5/08 7AM - "...Took AM meds. Staff reported individual vomited out after taking meds..." 4/5/08 7PM - "Refused to swallow whole pills. Accept and swallow pills broken down in pieces. No vomiting reported." 4/6/08 7AM - "Took all meds when broken down in pieces." 4/7/08 6:40 PM - "...Immediately after swallowing his antibiotics, he projectile vomiting and vomited up his Augmentin and Bactrim..." 4/8/08 6:15 AM - "... having trouble swallowing large antibiotic pills causing him to gag, pills given in apple cause one at a time after breaking in half..." There were additional nurse progress notes from April indicating choking, gagging and/or vomiting. Further review of the notes revealed nurses on different shifts had used different administration techniques; some nurses broke the pills into pieces while others did not. c. At 3:05 PM, review of a summary of Client #2's April 11, 2008 "Medication Review" by his medical team revealed no indication that the distress caused by the antibiotic pills had been discussed at their meeting. Review of the client's primary care physician (PCP) notes, dated May 7, 2008 and June 4, 2008, showed no evidence that the PCP had been made aware of the gagging and vomiting in April. d. Client #2's most recent episode of boils began	W 331	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass. The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	

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W 331	Continued From page 20 in June 2008. According to his Medication Administration Record, he began receiving Bactrim at 7 PM on June 20, 2008. He vomited on June 24th. There was no evidence that the facility established an effective means of communication within the nursing team, to ensure timely response to the client's medical concerns (i.e. vomiting pills), to include conveying relevant information to the primary care physician.	W 331	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive dental services, including restoration of teeth, for one of the two clients in the sample. (Client #2) The finding includes; Cross-refer to W120.2. The facility failed to ensure timely repair of Client #2's fractured tooth #9.	W 356	The follow up visit is scheduled for 9-15-08 In the future, the LPN Coordinator, and Qmrp will attach a copy of the previous visit consult to ensure that the dentist reviews the record of the last visit with the previous recommendations.	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	W 368		

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	09G065	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	4316 ALABAMA AVE, SE WASHINGTON, DC 20019

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W 368	Continued From page 21 facility failed to ensure that medications were given in compliance with physician's orders, for one of the two clients in the sample. (Client #1) The finding includes: On June 24, 2008, review of incident reports revealed that Client #1 had been hospitalized from January 13 - 30, 2008 with pneumonia and dehydration. Subsequent review of the health care services that he received just prior to the hospitalization revealed that a nurse had administered a decongestant (Sudafed) without seeking authorization from the primary care physician (PCP), as follows: Client #1's nurse progress notes indicated a temperature of 100.2 Fahrenheit on January 6, 2008, at 6 PM. The nurse documented having telephoned the PCP that day. On January 7, 2008, the client remained symptomatic (99.8 F). That same day, he was evaluated by the PCP, who prescribed Sudafed 60 mg every 6 hours as needed for congestion x 3 days, Tylenol 650 mg every 4 hours for fever, and encouraged fluids. The client's Medication Administration Record reflected that he received Sudafed as needed during the next three days, in accordance with the orders. However, further review of Client #1's nurse progress notes revealed that his symptoms continued beyond the 3-day period for which the PCP had prescribed the medications. A January 11, 2008 nurse progress note (at 6:15 AM), documented that she had administered Tylenol 2 tabs x 325 mg and Sudafed 60 mg because the client still had nasal drainage and had an elevated temperature (100 F). There was no evidence that	W 368	The medication nurses were inserviced by the LPN Coordinator regarding obtaining physician order prior to the administration of any medication The medication nurses were inserviced by the LPN Coordinator regarding obtaining physician order prior to the administration of any medication	7-31-08 7-31-08

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W 368	Continued From page 22 the medication nurse was authorized to extend the medication order, beyond the 3 days.	W 368		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adaptive mealtime equipment and failed to maintain in good repair a wheel chair for use by the one client (of four) whose plan included the use of a wheel chair. (Client #1) The findings include: 1. On June 24, 2008, at 8:27 AM, Client #1 was observed to ambulate slowly while walking out to the van. Direct support staff provided physical assistance in and out of the group home and the day program. On June 26, 2008, a wheel chair was observed to the left of the basement door, outside. A 2-inch long section of rubber was missing from the right rear tire. At 4:55 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that the wheel chair belonged to Client #1. The QMRP further indicated that she was previously unaware that the wheelchair needed repair. Subsequent review of Client #1's annual physical therapy (PT) assessment, dated November 17, 2007, revealed a recommendation for him to use a wheel chair	W 436	The 719A form's was submitted to Essential REhab for individual #1 to obtain a new wheelchair. The new wheelchair will be delivered to his new residence. In the future the facility will ensure that all of the adaptive equipment is in an operable condition, and ready for use.	7-31-08

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W 436	Continued From page 23 while out on community outings. According to the Individual Support Plan (ISP), dated November 21, 2007, "I ambulate independently for short distances, and require the use of a wheel chair for longer distances." Interview with the QMRP and the record review indicated the client went on frequent community outings with his housemates. There was no evidence, however, that the client's wheelchair had been maintained in good repair to maximize his mobility in the community. 2. Cross-refer to W120 and W484. Client #1 did not have available for use his prescribed adaptive eating equipment (HI-Lo plate with plate guard, small-bowled spoon with built-up handle, Dycem mat) at the day program. In addition, the facility had not yet purchased a smaller-bowled spoon (with a built-up handle). At the time of the survey, the spoon being used had a larger, tablespoon-sized bowl which presented more food with each mouthful than was recommended.	W 436	Refer to W 120 P.2 refer to W 484 P.2	7-24-08 7-24-08
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nutritional intake in accordance with prescribed dietary orders, for one of the two clients in the sample. (Client #2) The findings include: 1. According to Client #2's physician's orders	W 460		

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W 460	Continued From page 24 (POs), dated June 1, 2008, his diagnoses included hypertension. In addition to a low sodium diet, the client was prescribed three anti-hypertensive medications (Lisinopril 40 mg, Amlodipine 10 mg and HCTZ 25 mg). Breakfast was observed in the facility on June 24, 2008, beginning at 8:03 AM. The meal consisted of 2 slices of toast with jelly, 2 slices of reduced-fat turkey bacon, a bowl of cold cereal with 2% milk, coffee, water and orange juice. On June 26, 2008, at approximately 12:45 PM, review of the package of turkey bacon ("Fit & Active") revealed the statement "25% sodium of regular bacon" written prominently on the front panel. The label indicated that 2 slices contained 340 mg sodium. Minutes later, review of the menu in the kitchen revealed that persons prescribed a low sodium diet were to have "salt-free" bacon. The Qualified Mental Retardation Professional (QMRP) was present at that time. She stated that facility staff always purchased the same brand of bacon (Fit & Active) because it had 55% fewer calories. She then pointed to that pronouncement (55% fewer calories) written on the front panel. Observations and interviews revealed that the facility failed to ensure that Client #2 received a low sodium diet, to include salt-free bacon, in accordance with POs. 2. According to Client #2's POs, dated June 1, 2008, his diagnoses included hypercholesterolemia. In addition to a low fat low cholesterol diet, the client was prescribed Lipitor 10 mg. Breakfast was observed in the facility on June 24, 2008, beginning at 8:03 AM. The meal included a bowl of cold cereal with 2% milk. On June 26, 2008, at 1:00 PM, review of the menu in the kitchen revealed that persons on a low fat low cholesterol diet were to have skim milk.	W 460	All staff have been inserviced on client #2's diet In the future, the facility will ensure client #2 diet is implemented as prescribed. The facility will purchase the Low sodium items as indicated in his diet. The facility management will ensure that food items are purchased as prescribed. In the future, the house management will purchase food items as ordered.	7-31-08 6-30-08

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W 460	Continued From page 25 Subsequent inspection of the refrigerator revealed a container of 2% milk, only. Observations and interviews revealed that the facility failed to ensure that Client #2 received a low fat low cholesterol diet, in accordance with POs.	W 460		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Cross-refer to W120. On June 25, 2008, Client #1 was presented a sliced turkey sandwich. However, the client was prescribed a mechanical soft, low fat, high fiber diet (ground meats (moist with low fat gravy). There was no evidence the group home ensured that the prescribed ground meat with gravy was provided at the day program. 2. According to Client #2's physician's orders (POs), dated June 1, 2008, his foods were to be "finely chopped." On June 24, 2008, at 8:03 AM, the four clients were given 2 slices of reduced-fat turkey bacon with breakfast. Client #2's bacon, however, remained in strips and had not been finely chopped. There was no evidence that the facility ensured that his foods were consistently served finely chopped, in accordance with POs.	W 474	Refer to W 120 P.2 All staff have been inserviced on client #2 diet In the future, the facility will ensure client #2 diet is implemented as prescribed. The facility will purchase the Low sodium items as indicated in his diet.	7-31-08 7-31-08
W 484	483.480(d)(3) DINING AREAS AND SERVICE	W 484		

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W 484	Continued From page 26 The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that eating utensils, dishes and supplies were provided in accordance with assessed developmental needs, for one of the two clients in the sample. (Client #1) The findings include: 1. On June 24, 2008, at 8:03, AM, Client #1 was observed eating his breakfast. He ate from a Hi-Lo plate with a plate guard, using a built-up handle spoon which had a tablespoon-sized bowl and had a Dycem mat to keep his plate from sliding. Client #1 was generally independent in eating; however, staff had to give verbal prompts on occasion to slow his eating pace. Staff also intervened physically to reduce the amount of food that he scooped with the his spoon. Record verification later (see below) revealed that the client's annual Individual Support Plan (ISP), dated November 21, 2007, had recommended the use of a spoon with a smaller bowl to prevent overloading. The primary reason for the use of the adaptive equipment was that Client #1 was legally blind. 2. Cross-refer to W120. Client #1's prescribed adaptive equipment was not available for use at his day program. a. On June 25, 2008, at 12:06 PM, Client #1's	W 484	The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment are curently in the facility. 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program.	

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W 484	Continued From page 27 lunch was served at the day program on a Styrofoam plate and with a plastic fork. He had difficulty eating with the fork, as well as a plastic teaspoon. He resorted to eating with his hands. At 12:11 PM, the Styrofoam plate slid across the table while he was eating. There was no specialized adaptive equipment being used at the day program. Interview with day program staff indicated no specialized eating equipment had been provided to the day program for the client. Also on June 25, 2008, there was an updated Occupational Therapy (OT) assessment, April 5, 2008, in which the OT documented that he had observed Client #1 eating with his hand, and with his face down close to his plate. The OT also indicated that the direct support staff had informed him that the client often spilled his food when eating with the spoon. The April 2008 OT update included recommendations for Hi-Lo plate and the Dycem mat to prevent sliding. At the time of the survey, the Dycem mat was available for use in the home but not at the day program. b. On June 25, 2008, beginning at approximately 12:16 PM, review of Client #1's Individual Support Plan (ISP), dated November 21, 2007, revealed that he was prescribed "a plate guard and a spoon with a smaller bowl to prevent overloading of his utensil during mealtime." To date, the facility had not purchased spoons with smaller bowl for use in the home and at day program. There was no evidence that the facility ensured that Client #1 had all of the prescribed adaptive eating equipment/supplies available for use in all settings, to maximize self-feeding in accordance with his developmental level.	W 484	The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program. 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program. 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment are curently in the facility 7-29-08 The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment are curently in the facility 7-29-08	

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 24, 2008 through June 27, 2008. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. In addition, a focused review was conducted of a third resident's behavior support needs. The findings of this survey were based on observations at the group home and at two day programs, interviews with residents and staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 071	3503.2 BEDROOMS AND BATHROOMS Each bed shall be placed at least three feet (3 ft.) from any other bed and at least three feet (3 ft.) from any unprotected radiator. This Statute is not met as evidenced by: Based on observation, the Group Home for Mentally Retarded Person (GHMRP) failed to ensure a distance of at least three feet between resident beds was maintained. The finding includes: Observation of the Resident #1's bedroom on June 26, 2007 revealed the two beds in the room were placed approximately two feet apart.	I 071	The bedroom is currently unoccupied; the bed will be move when new residents move in.	
I 073	3503.3(b) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (b) Clean comfortable pillow; This Statute is not met as evidenced by:	I 073		

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I 073	Continued From page 1 Based on observation, the GHMRP failed to ensure each bedroom was equipped with at least the following items for each resident: (b) Clean, comfortable pillow; The finding includes: Observation of Resident #2's and #4's bed pillows on June 26, 2008, at approximately 3:20 PM, revealed they were flat.	I 073	The new pillows were purchased; the flat pillow was replaced by the new one.	7-31-08
I 077	3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage space for each resident ' s seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the bedroom contained sufficient storage space for each resident's clothing. The finding includes: Observation of Resident #2's and #3's bedroom closets on June 26, 2008, beginning at 3:10 PM, revealed that their shoes were stacked on top of each other.	I 077	The new shoe racks were purchased to accommodate the indivuals' shoes.	7-31-08
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.	I 090		

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I 090	Continued From page 2 This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a clean, orderly, and attractive manner. The findings include: On June 26, 2008, beginning at 2:54 PM, observation of the environment revealed the following deficiencies: 1. The device securing the blinds at the window in Resident 1's bedroom window was broken, which caused the blind to fall from the window when moved. 2. The top part of the entrance door to Resident #4's bedroom was observed to close tightly against the frame. This made it difficult to close the door completely. 3. Linoleum was not secured to the floor in the linen closet and in Resident #4's closet. Torn linoleum was also observed at the left side of the wardrobe in Resident #3's area of the bedroom. 4. A warped board was observed on the landing between the steps leading from the second floor to the ground (emergency exit). 5. The garbage disposal made a loud, scraping noise when it was the turned on. Staff indicated that this was not the noise was unusual. 6. The protective covering for the light fixture underneath the hood on the kitchen range was missing.	I 090	The new blinds were purchased on and will replace the broken one. In the future, the facility home management will ensure all blinds are in good repair. The top part of the entrance of door of individual #4's bedroom will be repaired Linoleum will be secured to the floor In the future, the home management will ensure that all floors are in good repair. The warper board was removed The garbage disposal was repaired In the future the home management will ensure that the garbage disposal is in good repair. The protective covering for the light fixture underneath the hood on the kitchen range was replaced	7-31-08 8-01-08 8-01-08 7-28-08 7-17-08 7-31-08

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I 090	Continued From page 3 7. The (vacant) bed located in Resident #1's bedroom was observed to have a mattress with palpable springs. Interview with the QMRP indicated that Resident #2 had recently moved from this room to another bedroom. There was no evidence that the mattress on each bed was maintained to ensure residents' comfort.	I 090	The new mattress will be purchased. In the future, the facility will ensure that the mattress on each bed ensures the resident's comfort.	8-05-08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: Review of the personnel records on June 26, 2008, beginning at 10:30 AM, revealed the following: 1. There was no current health certificates/ inventories provided for 1 of the 10 direct support staff (S6). The review of health records revealed that S6 had a tuberculin screening; however, there was no evidence that a physician's certification/ health inventory has been performed. 2. There were no current health certificates/	I 206		

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I 206	Continued From page 4 inventories available for the two medication nurses (N1 and N2). Further record review revealed that the health certificate for N1 had expired on February 10, 2007 and the one provided for N2 had expired on February 8, 2008. 3. There was no health certificate/ inventory available for review for the social worker (C3). 4. There health certificate/ inventory for the pharmacist (C2) had expired on May 31, 2008. This is a repeat deficiency. See deficiency report dated September 14, 2007.	I 206	The social Worker health certicate in currently on file. The Pharmacist health certificate is current, and was on file at the office. Refer to attachment # 8. In the future, the facility will ensure that personnel records are update, and availlable upon request	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four residents residing in the facility. (Residents #1, #2, #3, and #4) The findings include: 1. The facility failed to maintain evidence of CPR certification for each staff as follows: On June 26, 2008, at approximately 10:10 AM, review of staff and consultant records revealed no documented evidence of current Cardiopulmonary Resuscitation certification (CPR) available for 6 of the 10 direct support staff (S1, S2, S3, S4, S5 and S10) and N1. Interview	I 227	S1, S2, S6 and N1 CPR cards are currently on file. The remaining staff will take the class the CPR class 8-17-08	

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	HFD03-0178	A. BUILDING _____ B. WING _____	06/27/2008

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I 227	Continued From page 5 with the QMRP indicated that CPR cards should be current for some of the aforementioned staff. However, no additional documentation was provided before the survey ended. 2. The facility failed to maintain evidence of First Aid certification for direct care staff as follows: On June 26, 2008, at approximately 10:10 AM, review of staff and consultant records revealed no documented evidence of current first aid training available for 6 of the 10 staff direct support staff (S1, S2, S3, S4, S5 and S6). No additional documentation was provided before the survey ended. This is a repeat deficiency. See deficiency report dated September 14, 2007.	I 227	S1, S2, S5 first aid cards are currently on file. The remaining staff will take the first aid class on	8-17-08
I 396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (f) Occupational Therapy; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the professional license was available for the (f) occupational therapist.	I 396		

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I 396	Continued From page 6 The finding includes: Record review on June 27, 2008, at approximately 11:30 AM, revealed that the DC License for the Occupational Therapist (OT) had expired on September 30, 2007. Interview with the Qualified Mental Retardation Professional indicated that a current license for the OT should be available at the administrative office. However, no additional information was provided before the survey ended.	I 396		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: 1. Based on interview and record review, the facility failed to assess adaptive behaviors and/or independent living skills, for one of the two residents in the sample. (Resident #2) The finding includes: The facility failed to assess Resident #2's skills, strengths and deficits for participating and/or self-administration of finger sticks as follows: On June 24, 2008, at approximately 9:00 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Resident #2 was diabetic. On June 26, 2008, at 10:04 AM, the LPN Coordinator confirmed that the resident had been	I 401		

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I 401	Continued From page 7 diagnosed with diabetes approximately one year earlier, for which he received weekly finger sticks to monitor blood glucose levels. She further indicated that his willingness to participate in the finger stick process had not been assessed. At 12:03 PM, review of his physician's orders (POs) for June 2008 revealed "Finger stick in morning every week. Record glucose fasting blood sugar. Take weekly. Notify primary care physician if... 8/8/07 Wednesday finger stick." On June 27, 2008, at 1:27 PM, review of Resident #2's "Self-Medication Administration" assessment, dated December 10, 2007, confirmed that the resident's skills and/or willingness to participate in finger sticks for self-management had not been assessed. 2. Based on record review and interview, the facility failed to ensure timely nursing and medical services to meet resident needs, for one of the two residents in the sample. (Resident #2) The findings include: On June 24, 2008, at 6:19 AM, a direct staff person reported that Resident #2 "threw up his antibiotics" just moments earlier. The medication nurse reportedly had documented the incident in his record. This was later confirmed in the nurse progress notes. According to this same staff person, the nurse reportedly told her that they were "considering liquid medications instead." a. The QMRP and LPN Coordinator were interviewed later that morning, beginning at 9:07 AM. Resident #2 reportedly chewed his medications. Initially, the LPN Coordinator said she thought the antibiotic pills, which were larger than a typical pill, might have "a nasty taste." Yet,	I 401	The Nurse Coordinator has developped a goal for individual #2 to participate in his finger sticks for self-management. Refer to attachment # 5b In the future, the nursing team will ensure that self medication goals are deveopped to allow individual #2 self management.	7-28-08

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I 401	Continued From page 8 moments later both she and QMRP stated that the client "tolerates the chewing, taste" and had not complained. The antibiotics were prescribed for boils on his legs. They reported he was treated for a similar eruption on his legs in April 2008. The first boils had cleared but new ones appeared in June. Neither the QMRP nor the LPN Coordinator indicated that liquid medications were being considered. b. On June 26, 2008, beginning at 2:24 PM, review of Resident #2's Nurse Progress Notes revealed numerous entries documenting his difficulties with the antibiotic pills during the first round of antibiotic treatment in April, as follows: 4/5/08 7AM - "...Took AM meds. Staff reported individual vomited out after taking meds..." 4/5/08 7PM - "Refused to swallow whole pills. Accept and swallow pills broken down in pieces. No vomiting reported." 4/6/08 7AM - "Took all meds when broken down in pieces." 4/7/08 6:40 PM - "...Immediately after swallowing his antibiotics, he projectile vomiting and vomited up his Augmentin and Bactrim..." 4/8/08 6:15 AM - "... having trouble swallowing large antibiotic pills causing him to gag, pills given in apple cause one at a time after breaking in half..." There were additional nurse progress notes from April indicating choking, gagging and/or vomiting. Further review of the notes revealed nurses on different shifts had used different administration techniques; some nurses broke the pills into pieces while others did not. c. At 3:05 PM, review of a summary of Resident #2's April 11, 2008 "Medication Review" by his medical team revealed no indication that the distress caused by the antibiotic pills had been	I 401	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass. The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	

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I 401	Continued From page 9 discussed at their meeting. Review of the resident's primary care physician (PCP) notes, dated May 7, 2008 and June 4, 2008, showed no evidence that the PCP had been made aware of the gagging and vomiting in April. d. Resident #2's most recent episode of boils began in June 2008. According to his Medication Administration Record, he began receiving Bactrim at 7 PM on June 20, 2008. He vomited on June 24th. There was no evidence that the facility established an effective means of communication within the nursing team, to ensure timely response to the resident's medical concerns (i.e. vomiting pills), to include conveying relevant information to the primary care physician. 3. Based on interview and record review, the facility failed to ensure monitoring and coordination of Resident #2's daily dietary intake by a QMRP. The finding includes: According to a Nutrition quarterly, dated April 4, 2008, Resident #2 weighed 155 pounds in March 2008. The resident was assessed by his primary care physician (PCP) on June 19, 2008. The PCP noted a 7 pound weight loss within the past 2 months and ordered the facility to maintain a "food diary of all intake for 1 week." On June 26, 2008, at 12:41 PM, the QMRP presented a "Food Consumption Record" book for review. The FC Record book did not provide information regarding nutrient intake at his day program, Monday - Friday. When asked, the QMRP acknowledged that neither she nor the House Manager or the nurse had instructed the day program to maintain a record of his intake.	I 401	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass. The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass. The physician order to maintain a "food diary of all intakes for one week" was implemented in the facility; however, the Qmrp and nurse failed to ensure that day program is provided with the form to implement the physican order by collecting data. In the future, the facility will ensure that the prescribed services are implemented at the facility as well as at the day program.	

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I 401	Continued From page 10 Further interview revealed no evidence that the facility sought to determine Resident #2's nutritional intake while at day program for inclusion in the diary, as ordered by the PCP. [Note: At 5:47 PM, the Nutrition quarterly, dated April 4, 2008, indicated that Resident #2's body weight had dropped prior to April 2008. She documented a 10-pound drop from165 pounds in January 2008 to 155 pounds in February 2008.] 4. Based on interview and record review, the facility failed to ensure monitoring and coordination by a QMRP of Resident #3's behavior support needs, to effectively address food stealing, as follows: a. On June 24, 2008, at 6:47 AM, Resident #3 came down the stairs from his bedroom on the second floor. A staff person had been assisting him upstairs just moments earlier. That staff person, however, remained upstairs. Resident #3 quickly walked into the kitchen and removed a package of cookies from a cabinet. At 6:49 AM, he was observed standing alone in the kitchen and stuffing cookies into his pant pocket. A minute later, staff returned to the kitchen, unaware that the resident had just taken cookies and the resident left the kitchen hurriedly. On June 26, 2008, at 1:30 PM, the LPN Coordinator stated that one of Resident #3's targeted behaviors was securing foods between meals without authorization. She stated that he was "fast" and required constant staff supervision. The QMRP arrived minutes later. At approximately 1:36 PM, the QMRP also stated that Resident #3 moved quickly, adding that staff "must maintain visual" contact "at all times" or he will take advantage of the situation.	I 401	The physician order to maintain a "food diary of all intake for one week" was implemented in the facility; however, the Qmrp and nurse failed to ensure that the day program is provided with the form to implement the physician order by collecting data. In the future, the facility will ensure that the prescribed services are implemented at the facility as well as at the day program. All staff were re-inserviced on individual #3 BSP as well as on the individual monitoring. Refer to attachment #7 a & b In the future, the facility will ensure the Staff implement individual # 3 BSP as written, and monitor him frequently.	7-31-08

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I 401	Continued From page 11 On June 26, 2008, at 1:49 PM, review of Resident #3's Behavior Support Plan (BSP), dated December 2007, revealed that his diagnoses included Obsessive Compulsive Disorder and Intermittent Explosive Disorder. His targeted behaviors included "attempts to secure food... in excess of his dietary guidelines..." The QMRP, who was still present at the time, stated again that staff must keep the resident in sight at all times. This, however, was not explicitly outlined in his written BSP. Instead, the BSP indicated that in the past, he would take food if he was out of "direct visual supervision of staff i.e., more than 5 minutes..." The QMRP replied "no," when asked if he required one-on-one staffing. She also indicated that this had not been discussed by his interdisciplinary team. The QMRP stated that the facility had "ample staff." And yet during the same interview, she acknowledged that staff had found raw meat in Resident #3's pants pocket earlier that month. There was no evidence that the QMRP sought further input from the interdisciplinary team to address to the resident's ongoing behavior and review his supervision needs. b. Further review of the BSP revealed that staff were to "secure all edible items, when they are not being presented as part of a meal or snack time." The June 24, 2008 observation of Resident #3's taking cookies while unsupervised revealed the QMRP's failure to ensure that staff implemented effective measures to secure food items between meals.	I 401	All staff were re-inserviced on individual #3 BSP as well as on the individual monitoring. Refer to attachment #7 a & b In the future, the facility will ensure that the Staff implement individual # 3 BSP as written, and monitor him frequently. All staff were re-inserviced on individual #3 BSP as well as on the individual monitoring. Refer to attachment #7 a & b In the future, the facility will ensure that the Staff implement individual # 3 BSP as written, and monitor him frequently.	7-31-08 7-31-08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this	I 500		

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I 500	Continued From page 12 chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: I. Based on observation, interview and record review, the facility failed to establish and implement policies and procedures to prevent neglect and ensure residents' safety for two of two residents in the sample. (Residents #1 and #2) A. The facility failed to ensure that dietary textures and adaptive equipment were provided as prescribed to protect resident health and safety as evidenced below: 1. The QMRP and the LPN Coordinator were unaware of Resident #1's assessed risk for aspiration. On June 24, 2008, at 8:44 AM, interview with the Qualified Mental Retardation Professional (QMRP) and the LPN Coordinator indicated that Resident #1 was not known to be at risk of aspiration. They stated that his meats were to be "finely chopped" with gravy added "to be secure in the swallowing process, since he doesn't have any teeth to chew." Later that day, however, at approximately 12:16 PM, review of the resident's Individual Support Plan (ISP), dated November 21, 2007, revealed the following "I require monitoring for pace while eating and drinking. I must sip rather than gulp, due to risk of aspiration." The resident's physician's orders for June 2008 did not reflect "finely chopped. Instead, the diet order was as follows: "mechanical soft, low fat, high fiber diet, ground meats (moist with low fat gravy)."	I 500	Individual # 1 was relocated to another residence on however his new Qmrp will ensure that the day program provides the adequate services to individual #1. The Qmrp will report to the day program two (2) times weekly or as needed during mealtime to monitor the mealtime protocol in addition to the monthly monitoring starting Additionnally, the Qmrp will train the day program nurse and staff on individual #1 diet Refer to attachment #2 In the future the facility will ensure that the day program provides individual #1 diet as prescribed	7-03-08 7-31-08 7-31-08

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I 500	Continued From page 13 2. Resident #1's prescribed dietary texture was not implemented at his day program. On June 25, 2008, at 12:06 PM, Resident #1 was presented his lunch plate at the day program which included sliced turkey on whole wheat bread, ground tossed salad, peas in a cream sauce, fruit cocktail and beverages. At 12:14 PM, the resident had finished eating about 50% of the sandwich. The turkey was observed sliding out of the bread while the resident continued to bite into the sandwich. Using his fingers, he removed the turkey from the bread, put it in his mouth and continued taking bites of turkey. The day program nurse arrived while he was eating his lunch. She indicated that Resident #1 enjoyed his sandwiches whole and will get angry when they are cut. She also indicated that he will on occasion refuse to use a fork. At 12:16 PM, the resident was observed to cough several times. After completing his meal at 12:26 PM, the resident spit several pieces of fruit cocktail onto the floor and then coughed several times more. Further interview with the nurse revealed that he was prescribed a mechanical soft, low fat, high fiber diet (ground meats - moist with low fat gravy). There was no evidence that the day program provided Resident #1 with ground meat, as prescribed. 3. Resident #1's prescribed adaptive equipment was not available for use at his day program. On June 26, 2008, at 12:06 PM, Resident #1's lunch was served at the day program on a Styrofoam plate and with a plastic fork. He had difficulty eating with the fork, as well as a plastic teaspoon. He resorted to eating with his hands. At 12:11 PM, the Styrofoam plate slid across the table while he was eating. There was no	I 500	Individual # 1 was relocated to another residence on 7-03-08 however his new Qmrp will ensure that the day program provides the adequate services to individual #1. The Qmrp will report to the day program two (2) times weekly or as needed during mealtime to monitor the mealtime protocol in addition to the monthly monitoring starting 7-31-08 Additionnally, the Qmrp will train the day program nurse and staff on individual #1 diet 7-31-08 Refer to attachment #2 In the future the facility will ensure that the day program provides individual #1 diet as prescribed. The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment were provided to the day program 7-29-08	

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I 600	Continued From page 14 specialized adaptive equipment being used at the day program. Interview with day program staff indicated no specialized eating equipment had been provided to the day program for the resident. Also on June 25, 2008, there was an updated Occupational Therapy (OT) assessment, April 5, 2008, in which the OT documented that he had observed Resident #1 eating with his hand, and with his face down close to his plate. The OT also indicated that the direct support staff had informed him that the resident often spilled his food when eating with the spoon. The April 2008 OT update included recommendations for Hi-Lo plate and the Dycem mat to prevent sliding. At the time of the survey, the Dycem mat was available for use in the home but not at the day program. 4. Resident #1's prescribed spoon (built-up handle with small bowl size) was not available for use in the home or at his day program. On June 24, 2008, beginning at approximately 12:16 PM, review of Resident #1's Individual Support Plan (ISP), dated November 21, 2007, revealed that he was prescribed "a plate guard and a spoon with a smaller bowl to prevent overloading of his utensil during mealtime." To date, the facility had not purchased spoons with smaller bowl for use in the home and at day program. 5. The facility failed to verify that Resident #1 received an updated swallow study while hospitalized in January 2008 and to obtain the results for inclusion in the resident's record. On June 24, 2008, beginning at 7:31 AM, review	I 600	The Qmrp has ordered individual # 1 adaptive equipment on. These adaptive equipment were provided to the day program	7-24-08 7-29-08

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I 500	Continued From page 15 of incident reports revealed that Resident #1 had been hospitalized with pneumonia in January 2008 and again in June 2008. At approximately 9:50 AM, interview with the Incident Management Coordinator (IMC) revealed that although Resident #1 was "prone to develop pneumonia," he was not aware of any implications regarding his swallowing. At 10:07 AM, review of the resident's chart revealed that the most recent speech language assessment was dated January 15, 2007. The most recent documented, swallow study was performed on October 13, 2004 (due to frequent respiratory infections). The October 13, 2004 report indicated that the oral phase was within normal range. The esophageal phase, however, had not been viewed because the resident was unable to tolerate the position required for evaluation. The assessment, therefore, had not been comprehensive. On June 26, 2008, after the LPN Coordinator indicated that the hospital had conducted an updated swallow study in January 2008, review of the hospital discharge report, dated January 30, 2008, revealed: "He has passed all swallow evaluations and is eating a pureed diet currently with advancement as tolerated to full diet." Further interviews and record review revealed no evidence that the facility sought to obtain a copy of report(s) of any swallow studies that may have been conducted while he was hospitalized in January 2008. In addition, it was unclear whether the hospital had assessed the resident's tolerance of food textures other than pureed and had defined what they meant by "full diet." 6. Resident #2's prescribed dietary texture was not implemented in the facility. According to Resident #2's physician's orders (POs), dated June 1, 2008, his foods were to be	I 500	Individual # 1 former nurse will contact the Case Manager or attorney to request the copy of the swallowining studies completed while individual #1 was a the hospital.	7-31-08

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	HFD03-0178	A. BUILDING _____ B. WING _____	06/27/2008

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I 500	Continued From page 16 "finely chopped." On June 24, 2008, at 8:03 AM, the four residents were given 2 slices of reduced-fat turkey bacon with breakfast. Resident #2's bacon, however, remained in strips and had not been finely chopped. There was no evidence that the facility ensured that his foods were consistently served finely chopped, in accordance with POs. B. The facility failed to address timely Resident #2's repeated episodes of gagging and/or vomiting while taking large antibiotic pills. Cross-refer to I402. On June 24, 2008, at 6:19 AM, a direct staff person reported that Resident #2 "threw up his antibiotics" just moments earlier. The medication nurse reportedly had documented the incident in his record. This was later confirmed in the nurse progress notes. According to this same staff person, the nurse reportedly told her that they were "considering liquid medications instead." 1. The QMRP and LPN Coordinator were interviewed later that morning, beginning at 9:07 AM. Resident #2 reportedly chewed his medications. Initially, the LPN Coordinator said she thought the antibiotic pills, which were larger than a typical pill, might have "a nasty taste." Yet, moments later both she and QMRP stated that the resident "tolerates the chewing, taste" and had not complained. The antibiotics were prescribed for boils on his legs. They reported he was treated for a similar eruption on his legs in April 2008. The first boils had cleared but new ones appeared in June. Neither the QMRP nor the LPN Coordinator indicated that liquid medications were being considered and there was no evidence that the gagging/ vomiting had been identified as a concern.	I 500	All staff were inserviced on individual # 2 diet Refer to attachment #4 In the future, the facility will ensure that individual #2 diet is implemented as prescribed. The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass.	7-31-08 7-28-08 7-31-08

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I 500	Continued From page 17 2. Nurse progress notes from April indicating repeated choking, gagging and/or vomiting by Resident #2. Further review of the notes revealed nurses on different shifts had used different administration techniques; some nurses broke the pills into pieces while others did not. 3. There was no evidence that the PCP had been made aware of the gagging and vomiting in April. 4. There was no evidence that the facility established an effective means of communication within the nursing team, to ensure timely response to the resident's medical concerns (i.e. vomiting pills), to include conveying relevant information to the primary care physician. 5. There was no evidence that the QMRP effectively monitored Resident #2's medication tolerance. II. Based on interview and record review, the facility failed to ensure that all incidents were investigated by persons who had received training on investigation techniques, in accordance with the incident management policy, to protect client health and safety. The findings include: On June 24, 2008, at 8:21 AM, review of incident reports revealed that on April 27, 2008, Resident #1 fell off a chair and sustained a head injury when he hit his head against a wall. The corresponding investigation report was reviewed and disclosed conflicting information. Additionally, the investigation report was neither signed nor dated.	I 500	The LPN Coordinator spoke with the PCP, and obtained an order for data collection on individual # 2's medication tolerance for one week to determine if individual#2 has swallowing difficulty. 7-28-08 The medication nurses were inserviced on reporting any incident of difficulty swallowing medication. 7-31-08 Refer to attachment #5 In the future, the nursing department will ensure the physicain is informed of all the problems occuring during the medication pass. The medication nurses were inserviced to report any incident of difficulty ingesting medication to the nursing team, and the PCP on a timely manner for appropriate and immediate intervention. 7-31-08 The medication nurses were inserviced to report any incident of difficulty ingesting medication to the nursing team, and the PCP on a timely manner for appropriate and immediate intervention. 7-31-08 The QMrp will communicate with the nurse coordinator on a daily basis to follow up on the medication pass report. 7-31-08	

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I 500	Continued From page 18 The investigation report stated that he fell at 3:00 PM, whereas the incident report had stated that it had occurred at 5:25 PM. The investigation report indicated that staff had administered first aid, whereas the incident report showed the nurse had applied first aid (with no documentation that direct support staff had administered first aid). The investigation report stated that the resident's chair had been in the dining room, whereas the incident report indicated the chair had been located in the living room. On June 24, 2008, the Qualified Mental Retardation Professional (QMRP) was interviewed at 8:44 AM. The QMRP stated that she had conducted the investigation, beginning that same day. The QMRP acknowledged having failed to sign and date the report. She acknowledged that the 3:00 PM time indicated in the investigation report had been in error. She could not explain the discrepancy between the incident and investigation reports as to who had applied first aid to Resident #1's head, and at what time. On June 26, 2008, at 10:26 AM, review of the facility's Incident Management Policy, dated November 2007, revealed the following: The Incident Management Committee (IMC) shall "ensure that incidents are investigated in a timely manner and that they are documented and signed... Investigations shall be conducted only by employees of RCM who have completed competency-based investigative training conducted or approved by DHS/DDS." The facility policy also outlined what needed to be	I 500	The Qmrp was trained by the Incident Management Coordinator on the internal investigation. Refer to attachment # 1a Furthermore, the Qmrp is scheduled for the Incident Management training with DDS on Refer to attachment # 1b In the future the governing body will ensure that the person conductiong the investigation has received appropriate training in accordance with the facility policies. Furthermore, all investigation reports will be reviewed by the Incident Management Coordinator. The Qmrp was trained by the Incident Management Coordinator on the internal investigation. Refer to attachment # 1a Furthermore, the Qmrp is scheduled for the Incident Management training with DDS on Refer to attachment # 1b In the future the governing body will ensure that the person conductiong the investigation has received appropriate training in accordance with the facility policies. Furthermore, all investigation reports will be reviewed by the Incident Management Coordinator.	7-15-08 8-06-08. 7-15-08 8-06-08.

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I 500	Continued From page 19 included in investigation reports and further required that investigative reports "be reviewed and approved by RCM's IMC..." At 11:34 AM, the QMRP acknowledged that she had not attended DDS training on conducting investigations nor had she attended a comparable, approved training for investigators. During the June 27, 2008 Exit Conference, at approximately 4:00 PM, the facility's Incident Management Coordinator, Program Coordinator and the Chief Operating Officer all acknowledged that the April 27, 2008 incident and/or investigation report had not been reviewed by the IMC, in accordance with the facility's policy. It should be noted that the facility's 911 policy included "Head Injury" in the list of medical emergencies for which 911 should be called. 911 had not been called when Resident #1 sustained a one-inch cut on the back of his head "with minimal bleeding" on April 27, 2008, at 5:25 PM. A nurse progress note indicated that by 7:00 PM, a medication nurse had assessed him, provided first aid treatment and the resident was not taken to the ER. III. Based on staff interview and record review, the GHMRP failed to ensure timely dental services for Resident #2. The finding includes: On June 26, 2008, at 6:01 PM, review of Resident #2's dental records revealed that on September 10, 2007, the dentist determined that tooth #9 was fractured and needed restoration. The resident returned to the dentist on March 10, 2008 and had his teeth cleaned and polished. There was no mention of the September 10, 2007 assessment of tooth #9. At 6:05 PM, neither the	I 500	The 911 policy is revised to specify the head injury that requires ER visit for evaluation includes change in mental status such as confusion, loss of consciousness and changes in speech or communication, laceration and bleeding that can not be controlled with first aid treatment. Refer to attachment # 6	7-31-08

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I 500	Continued From page 20 QMRP nor the LPN Coordinator knew the status of tooth #9. The LPN Coordinator added that she would check with the dentist to see whether there had been a problem with securing authorization from the funding source (Medicaid insurance). IV. Based on observation, interview and record review, the GHMRP failed to ensure adaptive mealtime equipment and failed to maintain in good repair a wheel chair for use by the Resident #1. The findings include: 1. On June 24, 2008, at 8:27 AM, Client #1 was observed to ambulate slowly while walking out to the van. Direct support staff provided physical assistance in and out of the group home and the day program. On June 26, 2008, a wheel chair was observed to the left of the basement door, outside. A 2-inch long section of rubber was missing from the right rear tire. At 4:55 PM, Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the wheel chair belonged to Client #1. The QMRP further indicated that she was previously unaware that the wheelchair needed repair. Subsequent review of Client #1's annual physical therapy (PT) assessment, dated November 17, 2007, revealed a recommendation for him to use a wheel chair while out on community outings. According to the Individual Support Plan (ISP), dated November 21, 2007, "I ambulate independently for short distances, and require the use of a wheel chair for longer distances." Interview with the QMRP and the record review indicated the client went on frequent community outings with his housemates. There was no evidence, however, that the client's wheelchair had been maintained in good repair to maximize his mobility in the community.	I 500	The follow up visit is scheduled for 9-15-08 In the future, the LPN Coordinator, and Qmrp will attach a copy of the previous visit consult to ensure that the dentist reviews the previous recommendations. The 719A fomr was submitted to Essential REhab for individual #1 to obtain a new wheelchair. The new wheelchair will be delivered to his new residence. In the future the facility will ensure that all of the adaptive equipment is in an operable condition, and ready for use.	7-31-08

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I 500	Continued From page 21 2. Cross-refer to federal deficiency report, citations W120 and W484. Client #1 did not have available for use his prescribed adaptive eating equipment (Hi-Lo plate with plate guard, small-bowled spoon with built-up handle, Dycem mat) at the day program. In addition, the facility had not yet purchased a smaller-bowled spoon (with a built-up handle). At the time of the survey, the spoon being used had a larger, tablespoon-sized bowl which presented more food with each mouthful than was recommended. V. Based on observation, interview and record review, the GHMRP failed to ensure nutritional intake in accordance with residents' prescribed dietary orders, for one of the two residents in the sample. (Resident #2) The findings include: 1. According to Resident #2's physician's orders (POs), dated June 1, 2008, his diagnoses included hypertension. In addition to a low sodium diet, the resident was prescribed three anti-hypertensive medications (Lisinopril 40 mg, Amlodipine 10 mg and HCTZ 25 mg). Breakfast was observed in the facility on June 24, 2008, beginning at 8:03 AM. The meal consisted of 2 slices of toast with jelly, 2 slices of reduced-fat turkey bacon, a bowl of cold cereal with 2% milk, coffee, water and orange juice. On June 26, 2008, at approximately 12:45 PM, review of the package of turkey bacon ("Fit & Active") revealed the statement "25% sodium of regular bacon" written prominently on the front panel. The label indicated that 2 slices contained 340 mg sodium. Minutes later, review of the menu in the kitchen revealed that persons prescribed a low sodium diet were to have "salt-free" bacon. The QMRP	I 500	The Qmrp has ordered individual # 1 adaptive equipment on. 7-24-08 These adaptive equipment are curently in the facility. 7-29-08 All staff have been inserviced on client #2 diet 7-31-08 In the future, the facility will ensure client #2 diet s implemented as prescribed. The facility will purchase the Low sodium items as indicated in his diet.	

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I 500	Continued From page 22 was present at that time. She stated that facility staff always purchased the same brand of bacon (Fit & Active) because it had 55% fewer calories. She then pointed to that pronouncement (55% fewer calories) written on the front panel. Observations and interviews revealed that the facility failed to ensure that Resident #2 received a low sodium diet, to include salt-free bacon, in accordance with POs. 2. According to Resident #2's POs, dated June 1, 2008, his diagnoses included hypercholesterolemia. In addition to a low fat low cholesterol diet, the client was prescribed Lipitor 10 mg. Breakfast was observed in the facility on June 24, 2008, beginning at 8:03 AM. The meal included a bowl of cold cereal with 2% milk. On June 26, 2008, at 1:00 PM, review of the menu in the kitchen revealed that persons on a low fat low cholesterol diet were to have skim milk. Subsequent inspection of the refrigerator revealed a container of 2% milk, only. Observations and interviews revealed that the facility failed to ensure that Resident #2 received a low fat low cholesterol diet, in accordance with POs.	I 500	The facility management will ensure that food items are purchased as indicated in their diet order. In the future, the house management will purchase food items as ordered.	6-30-08

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R 000	INITIAL COMMENTS A licensure survey was conducted from June 24, 2008 through June 27, 2008. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. In addition, a focused review was conducted of a third resident's behavior support needs. The findings of this survey were based on observations at the group home and at two day programs, interviews with residents and staff as well as the review of clinical and administrative records, including incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and the review of records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person. The finding includes: On June 24, 2008, the Qualified Mental Retardation Professional (QMRP) was given a list of the names of employees for which documentation was needed to show evidence of criminal background checks. On June 26, 2008, review of the materials revealed no personnel information available for the House Manager (S5); therefore, there was no evidence of a background check for verification.	R 122	The house manager file is currently in the facility. In the future the facility will ensure that all personnel files information are on file, and available upon request.	7-20-08

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